

289107

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>EDNA ELLEN BOWIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-5-85</b>			2b. HOUR <b>5:00 A.M.</b>				
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-7-94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90 yrs.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD.				
10. CITY OR TOWN OF DEATH <b>INDIAN HEAD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHAPMANS LANDING RD. BOX 238</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>INDIAN HEAD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. BOX 235 ZIP 20640</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL A. GOODE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY D. WELCH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>214-32-8996</b>		17. INFORMANT <b>ADDRESS BOX 238</b> <b>VIOLA M. SABOL INDIAN HEAD, MD. 20640</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe atherosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Ventricular Arrhythmias; Recent Pulmonary Embolism;</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>82</b> , to <b>10-5-</b> 19 <b>85</b> that (I) (we) lost saw the deceased alive on <b>8-20-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>B. Kolia</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-5-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BASIRMOITMAD F. KOLIA M.D.</b>			22e. ADDRESS <b>9135 Piscataway Road, Clinton, MD 20735</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10-10-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NAZARENE CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PISCATAWAY CHARLES MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>AREHART FUNERAL HOME, INC. LA PLATA, MD.</b>			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John T. ...</b>					

MEDICAL CERTIFICATION

Notified at once

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 6 5 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CORDELIA H. BROWN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 28 1985</b>			2b. HOUR <b>11:30AM</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 6, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hughesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt-1 Box-273</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Hughesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt-1 Box-273 / 20637</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herman Heffner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mabel M. Kelly</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- - - 220-46-1079</b>			17. INFORMANT ADDRESS <b>Shirley A. Tefteau</b>			17b. ADDRESS <b>Rt-1 Box-47 Hughesville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE DATE BETWEEN ONSET AND DEATH <b>20637</b> <b>Yrs</b> <b>Yrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Diabetes</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/11/85</b> to <b>Oct 28/85</b> , that (I) (we) last saw the deceased alive on <b>10/11/85</b> , and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (If the individual did not view the body after death, so state.)										
22b. SIGNATURE <b>Leon W. Berube</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATES SIGNED <b>10/28/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leon W. Berube, M.D.</b>			22e. ADDRESS <b>Mechanicsville, Maryland 20659</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-31-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Hunt Funeral Home</b>			P. O. Box 156 ADDRESS <b>Waldorf, Md. 20601</b>			25a. DATE REC'D. BY REGISTRAR <b>10/30/85</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Taylor-Rodale</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the companion pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST Russel		MIDDLE		LAST Brown		2a. DATE KNOWN OF DEATH		MONTH 10		DAY 5		YEAR 1985		2b. HOUR 3 <sup>00</sup> PM							
3 SEX M	4 RACE B	5 DATE OF BIRTH MONTH 12		DAY 8		YEAR 85		6 AGE (IN YEARS) LAST BIRTHDAY 29 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 10		DAY 5		YEAR 1985		2d. HOUR 3 <sup>00</sup> PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.																	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction				12b. KIND OF BUSINESS OR INDUSTRY Private											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 1292 / 20677															
14. FATHER'S NAME FIRST Alvin						MIDDLE L.		LAST Thomas		15. MOTHER'S MAIDEN NAME FIRST Florence		MIDDLE M.		LAST Brown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						(IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Alvin L. Thomas		ADDRESS Box 1292 Port Tobacco, Md. 20677											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple trauma</u> 8199 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 <sup>00</sup> P.M. 10-5 1985						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Head on MVA											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street						21f. LOCATION STREET Rt 6						CITY OR TOWN Port Tobacco		COUNTY Charles		STATE MD	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE H.M. Mahan						TITLE (SPECIFY) Charles						M.D. MEDICAL EXAMINER						DATE SIGNED 5 Oct 85					
EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahan						ADDRESS S.R.#1 Box 1000 La Plata MD 20646																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Oct. 10, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Catherine's Church Cem.						23d. LOCATION CITY OR TOWN McChoncke						COUNTY Charles		STATE Md.	
24. FUNERAL DIRECTOR NAME Thorton						ADDRESS P.R. #1 Box 115 1 Ave Pomeroy, Md						25a. DATE REC'D. BY REGISTRAR Oct 14 1985						25b. REGISTRAR'S SIGNATURE John T. ...					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROLAND A. COLUZZI</b>			2a DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 6, 1985</b>		2b HOUR <b>1:15 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 28, 1930</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN) <b>Washington, D.C.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b> MD.		
10 CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIANS MEMORIAL HOSPITAL</b>		12a USUAL OCCUPATION (TYPICAL WORK FOR MOST OF WORKING LIFE) <b>Vice Principal</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b CITY OR TOWN <b>Charles Waldorf</b>	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET ADDRESS / ZIP CODE <b>Box 326C1 Waldorf Md. 20601</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Nazzareno E. Coluzzi</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louisa Vita</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>Coast 578-34-8728</b>	17 INFORMANT NAME ADDRESS <b>Nazzerino Coluzzi 10200 Griff Dr. Ft. Washington, Md 20744</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> <b>2 years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> <b>28 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <b>19 85</b> to <b>19 85</b> , that (I) (we) last saw the deceased alive on <b>Aug 22 19 85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>James M. Moss</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>10-7-85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES M. MOSS, M.D.</b>		22e ADDRESS <b>1707 O'Sage St., Alexandria, Virginia</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>10-09-85</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P. G. Maryland</b>		
24 FUNERAL DIRECTOR <b>Lee Funeral Home, Inc.</b>		25a DATE REC'D. BY REGISTRAR <b>20735</b>	25b REGISTRAR'S SIGNATURE <b>OCT 15 1985</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed by the physician 24 hours after death. Page 4 must be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must file a copy of this certificate with the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Grace Virginia Cooksey</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 14, 1985</b>					2b. HOUR <b>8 25 P.M.</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 21, 1909</b>			6 AGE (IN YEARS, LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.					
10 CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a STATE <b>MD.</b>		13b COUNTY <b>CHARLES</b>		13c CITY OR TOWN <b>INDIAN HEAD</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>P.O. BOX 144 20640</b>			
4 FATHER'S NAME FIRST MIDDLE LAST <b>THOMAS COOKSEY</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATE LACEY</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b SOCIAL SECURITY NO. <b>215-70-1386</b>		17 INFORMANT ADDRESS <b>Wm. Spencer Cooksey Same as #13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (if this hospital) attended the deceased from <b>10/9</b> 19 <b>85</b> to <b>10/14</b> 19 <b>85</b> that (we) last saw the deceased alive on <b>10/14</b> 19 <b>85</b> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gay H. Waldorf</b> DEGREE						22c. DATE SIGNED <b>10/14/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GAY H. WALDORF</b>						22e. ADDRESS <b>Waldorf La Plata, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>10-17-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Mem. Garden</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Charles Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Arehart Funeral Home, Inc.</b> ADDRESS <b>La Plata, Md</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1985</b>			25b. REGISTRAR'S SIGNATURE <b>John A. ...</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Margerite Dorothea Cramer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 22, 1985</b>		2b. HOUR <b>3:40a</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10/28/21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.	
10. CITY OR TOWN OF DEATH <b>La Plata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retailer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Garfinkel's</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>Charles</b>	13c. CITY OR TOWN <b>La Plata</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl H. Cramer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Marie Salzman</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-1069</b>		17. INFORMANT <b>Brother</b> ADDRESS <b>P. O. Box 1103 La Plata, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>6/1/82</u> to <u>10/22/85</u> , that (I) (we) last saw the deceased alive on <u>10/21/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Khadar Baig</u>		DEGREE <u>MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Khadar Baig, M.D.</b>		22e. ADDRESS <b>La Plata, Md. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>10/23/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Huntt Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles MD</b>	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, P. O. Box 156, Waldorf, MD</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Charles</b>	

MEDICAL CERTIFICATION

35

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 2) and page 3 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John W. Doniver</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 17, 1985</b>		2b. HOUR <b>9:32p M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 2, 1923</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chauffeur</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Indian Head</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John David Doniver</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Keys</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>218-16-3046</b>		17. INFORMANT <b>Rose Howard</b>		
16c. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		ADDRESS <b>Indian Head, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma Lungs</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>April 19, 85</b> to <b>10-17-1985</b> that (I) (we) last saw the deceased alive on <b>10-17-1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Worrell</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-18-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Girija Rath, M.D.</b>		22e. ADDRESS <b>Waldorf, Md. 20601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-21-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham P.G. Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Thornton Funeral Home</b>		ADDRESS <b>Pomonkey, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1985</b>		
		25b. REGISTRAR'S SIGNATURE <b>Girija Rath</b>				

MEDICAL CERTIFICATION

5-1-85  
62-35-85  
85-1-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10-15-88



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bernard A. Greenfield</b>		2a. DATE OF DEATH KNOWN ESTIMATED <b>2 10 28 19 85</b>		2b. HOUR <b>12 26 A M</b>	
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 17 17 68</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>17</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>LA PLATA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PHYSICIAN'S MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>FARMER</b>	
13a. STATE <b>MD.</b>		13b. CITY OR TOWN <b>CHAS. BRYANTOWN</b>		13c. STREET ADDRESS <b>P.O. BOX 98 20617</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ARTHUR DOCKETT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BEATRICE WADE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>220-12-7235</b>		17. INFORMANT <b>MADELINE GREENFIELD</b>		ADDRESS <b>SAA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>100 Ds</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>H. Mahan</b>		TITLE (SPECIFY) <b>M.D. Charles C.</b>		DATE SIGNED <b>28 Oct 85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>H. Mahan, Asst M</b>		ADDRESS <b>58th Box 1020 LaPlata, Md 20616</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>31 OCT '85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARV'S CATH CH. CEM</b>	
24. FUNERAL DIRECTOR NAME <b>Marshall Adams, Aquasco, Md. 20608</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 08 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson - Registrar</b>	
23d. LOCATION OR TOWN <b>BRYANTOWN, CHAS. MD.</b>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

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25MBP  
DHMH - 17  
(VR A15 ME (5))

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
1 - STATE  
REGISTRAR

REG. NO.

302030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is not, injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>SEVINA B. BRUNK HATRICK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>Oct - 24 85</b>		2b. HOUR MIN. <b>11 40 AM</b>	
3. SEX <b>F</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN Nsg. CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>CHARLES</b>	13c. CITY OR TOWN <b>WALDORF</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Brunk</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Eva Gehrhardt</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>064-05-6350</b>		17. INFORMANT <b>niece</b> ADDRESS <b>Helen S. Brettman same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Organic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Autoaccidents</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-1-1984</b> to <b>10-24-1985</b> , that (I) (we) lost saw the deceased alive on <b>10-24-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, add: I did not; view the body after death.)					
22b. SIGNATURE <b>DANIEL HOWELL</b>				22c. DATE SIGNED <b>10-24-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL HOWELL</b>				22e. ADDRESS <b>LAPLATA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10/25/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Huntt Crematory</b>	
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles MD</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 25 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

305030

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OLIVE E. HEALEY			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 28, 1985			2b. HOUR 3:10 a.m.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR November 8, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY MD.				
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7080 Cradle Rock Way 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph A. Walbert			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Etta Harris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 218-09-7292		17. INFORMANT ADDRESS William H. Healey 601 Dream Landing Way Annapolis, MD. 21401					
18. CAUSE OF DEATH: Enter only one cause primary for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure secondary to myocardial infarction.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>Due to, or as a consequence of, Myocardial infarction.</i> <i>Due to, or as a consequence of, Atherosclerotic cardiovascular disease.</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Osteoarthritis with recent hip fracture</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/18</i> , 19 <i>85</i> , to <i>10/28</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10/27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>George Wathen</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>10/28/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE WATHEN, M.D. <i>(H.M. Grant)</i>						22e. ADDRESS LA PLATA, MARYLAND 20646				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <i>med cert</i> 10/31/85		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine</i> Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228						25a. DATE REC'D. BY REGISTRAR <i>10/29/85</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and advised.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 is marked, the body must be buried or cremated within 72 hours after death.

If the deceased was a member of the armed forces, the individual must be buried in a military cemetery.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles Henry Hill</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-20-85</b>		2b. HOUR P <b>9:58 M</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 10, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD.			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>LA PLATA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt.#4 Box 4007 20646</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Dyson Hill</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie Browner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-24-2329</b>		17. INFORMANT ADDRESS <b>Doris L. Hill Same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>12 hrs</b> <b>10 days</b>	
								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>pseudomembranous colitis, dehydration, kidney failure, pneumonia</b>	
19a. DATE OF OPERATION <b>Oct 10/15/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ovarian incision on TPN</b>			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>N/A</b> 19 <b>85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>85</b> , to <b>10/21</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul Pritchett</b> M.D.					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>10/21/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Pritchett, M.D.</b>					22e. ADDRESS <b>La Plata, Md, 20646</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-24-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Plata Charles Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Arehart Funeral Home, Inc. La Plata, Md</b>					25a. DATE REC'D. BY REGISTRAR <b>Oct 25 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Judith Davidson</b>		

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Items 18-22a 12/11/85 mfb F3610 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
GARNEL LEROY JOHNSON						10 13 85									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE		BLACK		JAN. 22, 59		26 YRS.		MONTHS DAYS		HOURS MIN.		10 14 85		12:51 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND				UNITED STATES								Charles County MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Nanjemoy				Md. Rt. 6 west of Holly Spring Rd.				CONSTRUCTION				PRIVATE			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
MARYLAND				CHARLES				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				BOX 115A 20662			
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST								FIRST MIDDLE LAST							
THOMAS A. JOHNSON								MARY D. TIBBS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT			
NO								N/A				218-80-4411 MARY D. JOHNSON NANJEMOY, MD. 20662			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Multiple injuries															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR				Pedestrian struck by motor vehicle							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				road				Md. Rt. #6 west of Holly Springs Rd. Charles County MD.							
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED			
Ann M. Dixon, M.D.				M.D. Assistant MEDICAL EXAMINER								10-14-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Ann M. Dixon, M.D.				111 Penn ST., Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				OCT. 17, 85				OAK GROVE CHURCH				GRAYTON CHARLES MD.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE			
THORNTON'S FUNERAL HOME POMONKEY, MD.				25c. 12 1985											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25MDHMH - 17  
(VR A15 ME (5))

2001002

REBIL MOTION 8002

QMD WHITEHEAD

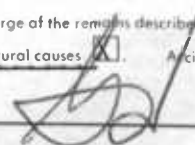



1002002

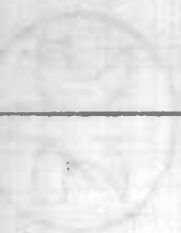
304164

DIVISION OF VITAL RECORDS, 201 W. BROAD ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFERMENT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BROAD STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REINTERMENT.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM Franklin JONES</b>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10-15-85</b>		2b. HOUR <b>2:12P</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>05 03 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>50</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-15-85</b>		2d. HOUR <b>19</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Charles County</b> MD.				
10. CITY OR TOWN OF DEATH <b>LaPlata</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter/Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>			
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Louisa</b>		13c. CITY OR TOWN <b>Louisa</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1, Box 458</b> <b>Louisa, Virginia 23093</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Eugene Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie Badgett</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>225-40-9512</b>		17. INFORMANT <b>Frances J. Smith,</b>				ADDRESS <b>Rt. 1, Box 458</b> <b>Louisa, Va. 23093</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b>											
(c) <b>seizure disorder</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b> M.D.				MEDICAL EXAMINER		DATE <b>10-16-85</b> SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/18/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Louisa, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Jew Light</b>		ADDRESS <b>Box 338</b>		CITY <b>Louisa, Va.</b>		STATE <b>23093</b>		25a. DATE REC'D. BY REGISTRAR <b>23 1985</b>		25b. REGISTRAR'S SIGNATURE 	

DHMH - 17  
(VR A15 ME (5))





296023

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- DECEASED NAME (TYPE OR PRINT) <b>WILLIAM EARNEST KING</b>							2a DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>10 12 85</b>		2b HOUR <b>12 A</b>		
3 SEX <b>Male</b>		4 RACE <b>CadW</b>		5 DATE OF BIRTH MONTH <b>Oct 21</b> DAY <b>1929</b> YEAR <b>55</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>55</b>		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		2c DATE PRONOUNCED DEAD <b>10 12 85</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>				7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>	
10 CITY OR TOWN OF DEATH <b>LaPlata</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Mem. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Pisgah</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt-425 (Gen Del) / 20640</b>	
14 FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>E.</b> LAST <b>King</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Iva</b> MIDDLE <b>J.</b> LAST <b>Lantz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>1949-1953</b>		17. INFORMANT <b>George G. King</b>		18. ADDRESS <b>Box 186A Medford, N.J. 08055</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8147</b> IMMEDIATE CAUSE (a) <b>multiple trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:45 A.M. 10 12 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>struck pedestrian (by auto)</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET <b>Rt 6</b> CITY OR TOWN <b>McCormick</b> COUNTY <b>Charles</b> STATE <b>Md</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>H.M. Mahan-Haft</b>				TITLE (SPECIFY) <b>Charles</b>				DATE SIGNED <b>12/01/85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>H.M. Mahan-Haft MD</b>				ADDRESS <b>SR#1 Box 1020 LaPlata, Md 20646</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-16-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Vets. Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Cheltenham, Pr. Geo., Md.</b> COUNTY <b>Charles</b> STATE <b>Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b>				ADDRESS <b>P.O. Box 156 Waldorf, Md. 20601</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John K. ...</b>	



298124

#5,6,15,17,FilmG613 3/18/86 kam

8 5 2 8 0 0 0

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph H. Kozak			2a. DATE OF DEATH MONTH DAY YEAR October 21, 1985		2b. HOUR A M 9:25 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb 26, 1915 <del>Jan. 25, 1950</del>		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Truck Co. Mayflower	
13a. STATE Maryland			13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Kozak			15. MOTHER'S MAIDEN NAME FIRST LAST Teresa Podheridecki		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 278-01-8373		17. INFORMANT Kozak Kathryne Kozak	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael A. Leatherwood, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Leatherwood, M.D.		22e. ADDRESS Rt. 301, So., Box 8 & 9, Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-21-85		23c. NAME OF CEMETERY OR CREMATORY Georgetown Med Sch	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME COLUMBIA MORTUARY SVCS		24b. REGISTRAR'S SIGNATURE S. Davidson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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281023

ITEM NUMBER 13- PER. PH. CALL  
FOR 10-9-85 D.W.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 6 6 7

1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Edgar W Kuhl			2a DATE OF DEATH MONTH DAY YEAR October 2 1985		2b HOUR P 6:23P
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1901	6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		
10 CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Engineer	12b KIND OF BUSINESS OR INDUSTRY Westinghouse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Charles	13c CITY OR TOWN Brians Road	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Kuhl			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Schomaker		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 170-01-4862	17 INFORMANT ADDRESS Brians Rd Isabelle Kuhl 306 Amherst Rd Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE CARDIAC FAILURE, HYPERTENSION, CHRONIC AIRWAY FB					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 10/2/85 19, to 10/2/85 19, that (I) (we) last saw the deceased alive on 10/2/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Sanjeeb Mishra		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/2/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Sanjeeb Mishra, M.D.		22e ADDRESS Waldorf, Maryland 20601			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b DATE 10-3-85	23c NAME OF CEMETERY OR CREMATORY Georgetown Med Sch	23d LOCATION WASHINGTON, COUNTY D.C.	DATE.	
24 FUNERAL DIRECTOR Columbia Mortuary Services 2254 MISSOURI AVE, NW WASHINGTON, D.C. 20001		25a DATE REC'D. BY REGISTRAR 7. 1985			
		25b REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

SP0033



RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL FORCES



318010

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 6 6 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Norman Sylvester Lake			2a. DATE OF DEATH MONTH DAY YEAR October 31, 1985		2b. HOUR A 9:20 M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Tres. Dept.			
13a. STATE Md.			13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE St.Rt.#5 Box 452 20646 Ellenwood Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST Frank S. Lake			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Ann Wilde								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 071-03-4870		17. INFORMANT ADDRESS Norma S. Dinan Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line, and only one cause per line) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE RESPIRATORY FAILURE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY OEDEMA. CARENIC VENTRICULAR ARRHYTHMIA, GLAUCOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/29/85 19, to 10/31/85 19, that (I) (we) last saw the deceased alive on 10/30/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Sanjeeb K. Mishra			DEGREE			22c. DATE SIGNED 10/31/85			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sanjeeb K. Mishra, M.D.			22e. ADDRESS Charles Prof. Center, #200, Waldorf, Md. 20601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-4-85		23c. NAME OF CEMETERY OR CREMATORY National Mem.Park			23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR Nov 08 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove cause of death papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

October 11, 1952

Mr. J. Edgar Hoover

RE

100-21,120

LAWYER

X

RECEIVED

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C.

Mr. J. Edgar Hoover

Director, FBI

SIR:

Enclosed for you

are two copies of a

letterhead memorandum dated and captioned as above.

Very truly yours,

J. Edgar Hoover

cc - Mr. Tolson

Mr. Clegg

cc - Mr. Glavin

cc - Mr. Ladd

cc - Mr. Nichols

cc - Mr. Rosen

cc - Mr. Tracy

cc - Mr. Harbo

288012

1- FOR  
STATE  
REGISTRAR#28 per M.E. OFF.  
10/10/85 KmSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28009

1. DECEASED NAME (TYPE OR PRINT)			FIRST CHRISTINE ELAINE			MIDDLE LANGLEY			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED			X1 MONTH DAY YEAR 10-2-85 19			2b. HOUR M 4PM					
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9/5/85		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 27		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-2-85 19		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD											
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN U.S. CITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY N/A			
10. CITY OR TOWN OF DEATH LaPlata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN U.S. CITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY N/A											
13a. STATE MD				13b. CITY OR TOWN Pr. Geo.				13c. CITY OR TOWN Brandywine				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 16811 Aquasco Road							
14. FATHER'S NAME FIRST MIDDLE LAST David Keith Langley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Debra Jean Merryman				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None				17. INFORMANT Father David K. Langley ADDRESS same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER 111 Penn Street				DATE SIGNED 10-3-85											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/5/85				23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brandywine, Pr. Geo., MD			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD				ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 7 1985				25b. REGISTRAR'S SIGNATURE John F. ...											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25MBP  
DHMH - 17  
(VR A15 ME (5))

Female White 9/2/52

Age 12

17. 100.

David Smith

-----

Franklin

Langley

One



80%

1952 2 St. Paul's Cemetery, Minneapolis, Minn.

Robert J. Smith

305054

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 5 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRED ELMORE LES CALLETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 21 85</b>		2b. HOUR <b>9:10 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 28 17</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH. D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES CO. MD.</b>		
10. CITY OR TOWN OF DEATH <b>LA PLATA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HERIDIAD NSG-CTR</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Const. Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Md.</b>	13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN <b>SUITLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>4712 HURON AVE 20716</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM EDWARD LES CALLETT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELSIE MARIE NALLY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII 578-18-3248</b>		17. INFORMANT ADDRESS <b>Juanita Les Callett Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Oat Cell Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accidents</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/3</b> 19 <b>84</b> , to <b>10/21</b> 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>10/17</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <b>G. W. WATKINS</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/22/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. W. WATKINS</b>		22e. ADDRESS <b>LA PLATA, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>10-22-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton P.E. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Archant Funeral Home</b>		ADDRESS <b>LA PLATA, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>OCT 25 1985</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the attending physician complete and sign this certificate of death within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please return the remaining pages, page 1, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified at once.

BP \_\_\_\_\_

WILLIAM L. WHITE  
1125 A  
CHARLES CO.

WILLIAM L. WHITE  
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CHARLES CO.

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WILLIAM L. WHITE  
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CHARLES CO.



311140

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

65 28671

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Henry Patterson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 24, 1985</b>		2b. HOUR A <b>12:05 M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 2, 1910</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b> MD			
10. CITY OR TOWN OF DEATH <b>La Plata</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bread Co.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Nanjemoy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. Box 17 20662</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry H. Patterson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Dailey</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII 413-03-8129</b>		17. INFORMANT <b>Alberta Patterson</b>				ADDRESS <b>Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Cancer Colon</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>6 mos</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3</b> 19 <b>84</b> to <b>10-23</b> 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>10-23</b> 19 <b>85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>						DEGREE		22c. DATE SIGNED <b>10-24-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Howell, M.D.</b>						22e. ADDRESS <b>Box 20, Charles Prof. Bldg., Waldorf, Md. 20601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-26-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Arehart Funeral Home, Inc. La Plata, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>11-30-85</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 6 7 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <i>Julia KATHERINE Pickeral</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Oct 10, 1985</i>		2b. HOUR <i>3:33 A M</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>05/21/1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92.</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles.</i> MD.	
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Physicians Memorial Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>119 Terrace Dr. Waldorf, Md. 20604</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Chas.</i>		13c. CITY OR TOWN <i>Waldorf</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Morris Pickeral</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jane Pickeral</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>214-12-7736</i>		17. INFORMANT ADDRESS <i>Niece: house Derman Waldorf, Md. 20604</i>	

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Irreversible respiratory collapse</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 30 min</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>Cardiac arrest</i>	<i>1 hr 30 min</i>
	(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>June 19 49</i> to <i>Oct 10 19 85</i> that (I) (we) last saw the deceased alive on <i>10/10 19 85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur O. Woody, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10.10.85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARTHUR O. WOODY, MD</i>				22e. ADDRESS <i>Bx 430 LA PLATA, MD. 20646</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/12/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakland Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waldorf Charles MD</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Huntt Funeral Home, Waldorf, MD</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 14 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Walter D. Anderson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 lists any injury, or other traumatic event, the medical examiner must be notified at once.

BP



296018

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN PHILIP PILKERTON			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1985		2b. HOUR 9:30 A.M.
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 28, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U. S. OF A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY, MD.		
10. CITY OR TOWN OF DEATH WHITE PLAINS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PICKERAL STREET	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRK. DRIVER	12b. KIND OF BUSINESS OR INDUSTRY S.H.A.		
13a. STATE MARYLAND		13b. COUNTY CHARLES	13c. CITY OR TOWN WHITE PLAINS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS PICKERAL STREET 20695
14. FATHER'S NAME FIRST MIDDLE LAST JOHN THOMAS PILKERTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES REGINA FLANAGAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-30-4026	17. INFORMANT ADDRESS R. Irene Pilkerton, La Plata, Md. 20646		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Respiratory Collapse		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Min.
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma		2 Wks.
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Pancreas		9 Wks.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Jaundice, Secondary to Obstructive Pancreatic Tumor

19a. DATE OF OPERATION July 30, 1985	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor; Mass in Abdomen: Pancreatic	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="radio"/> this hospital attended the deceased from June 19 50 to October 12, 85 that <input checked="" type="radio"/> I saw the deceased alive on October 12, 19 85, and that in my <input checked="" type="radio"/> own opinion death occurred on the date and hour and from the causes stated above, <input type="radio"/> (we) <input type="radio"/> (did not) view the body after death.			
22b. SIGNATURE Arthur C. Woody. MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10.12.85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR C. WOODY, MD.		22e. ADDRESS Box 430 LA PLATA, MD 20646	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/15/85	23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal	23d. LOCATION CITY OR TOWN COUNTY STATE Wayside Charles Md.
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC., LA PLATA, MD.		25a. DATE REC'D. BY REGISTRAR OCT 17 1985	
		25b. REGISTRAR'S SIGNATURE John A. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

358018

Handwritten notes and stamps, including a circular stamp with the number 10.

THE UNIVERSITY OF CHICAGO  
JANUARY 22, 1939  
TO THE PRESIDENT OF THE UNIVERSITY OF CHICAGO  
FROM THE DEAN OF THE FACULTY  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a letter or report.]

305067

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M
 BP  
DHMH 17  
(VR A15 ME (5))

FOR THE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										2 8 6 7 4	
1- STATE REGISTRAR										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL Wayne PITCHER										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10-11-85										2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1951		6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTH DAY YEAR		7c. DATE PRONOUNCED DEAD 10-16-85		7d. HOUR 9:30A							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.									
10. CITY OR TOWN OF DEATH Indian Head				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac River off Indian Head, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief engineer				12b. KIND OF BUSINESS Merchant Marines									
13a. STATE Maryland										13b. CITY OR TOWN Calvert		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS General Delivery, 20615							
14. FATHER'S NAME FIRST MIDDLE LAST Alan T. Pitcher, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet E. Dove											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT Alan T. Pitcher, Sr., Same as # 13-A-E				ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8329 IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5PM, 10-11-85				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subj. apparently lost balance fell over													
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river				21f. STREET CITY OR TOWN COUNTY STATE Potomac River Indian Head, Maryland													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>Margarita A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER Margarita A. Korell, M.D.				DATE SIGNED 10-17-85									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-19-1985				23c. NAME OF CEMETERY OR CREMATORY Broomes Island Wesleyan				23d. LOCATION CITY OR TOWN COUNTY STATE Broomes Island, Calvert, Md.									
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
Rt. 264, Box 34B, Port Republic, Maryland 20676																					

730206

2000 COTTON FIBER

WAX  
DOWD





296020

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE GIVEN TO WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>George JOSEPH Proctor</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>10 12 85</b>		2b. HOUR <b>11:00 A.M.</b>		
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 29, 1916</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>10 12 85</b>		2d. HOUR <b>12:35 P.M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. of A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County, Md.</b>					
10. CITY OR TOWN OF DEATH <b>Spring Hill</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 301</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pumber-Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School Brd.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		
13c. CITY OR TOWN <b>Spring Hill</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Route 301</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar Proctor</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carolyn Butler</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-16-2510</b>		17. INFORMANT <b>J. Herman Proctor</b>		ADDRESS <b>St. Rt. 1 Bx 1152 Port Tobacco, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gunshot wound to chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>gunshot wound to chest</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1130 P.M. 10-12 1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self inflicted gunshot wound</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>364 Springhill rd. Capital Charles MD</b>						
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>H.M. Mahan</b>				TITLE (SPECIFY) <b>Dr. Proctor</b>				DATE SIGNED <b>10-12-85</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>H.M. Mahan</b>				ADDRESS <b>SPR#1 Box 1020 Capital, Md 20641</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/16/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pomfret Charles Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Arehart Funeral Home, Inc., La Plata, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julian Davidson</b>			



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Linda			MIDDLE Denise			LAST Reese			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10/ 2/ 1985			2b. HOUR M P								
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1955		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10/ 2/ 19 85			2d. HOUR 1:39 P M								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.											
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor				12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE Maryland				13b. COUNTY Prince George				13c. CITY OR TOWN Upper Marlboro				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 102 Graiden Street 20772									
14. FATHER'S NAME FIRST MIDDLE LAST Linwood T. Binford, Jr.									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy L. Taylor														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 578-78-7385				17. INFORMANT Linwood T. Binford, Jr., father, same address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10/2 1985						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) unknown											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street						21f. LOCATION STREET CITY OR TOWN COUNTY STATE Turkey Hill Rd. LaPlata, Maryland											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																							
ACTUAL SIGNATURE <i>Margarita A. Korell</i>						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 10/3/85											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn St.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Oct. 8, 1985						23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park						23d. LOCATION CITY OR TOWN COUNTY STATE Highland Park, Maryland					
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc.												25a. DATE REC'D. BY REGISTRAR OCT 15 1985						25b. REGISTRAR'S SIGNATURE <i>J. A. Davidson</i>					
7400 Georgia Ave. NW, Washington, DC 20012																							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

20% COLLECTIBLE

MARKET

DOWN



Good at a price

288029

Items 23athru23dPer F.H.10/7/88  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 5 2 8 6 7 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL ROBERTA ROBEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 2, 1988</b>		2b. HOUR <b>10<sup>00</sup> P<sup>M</sup></b>	
3 SEX <b>Female</b>		4 RACE <b>Can.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>03 13 02</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD - ChasCo</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9 BALTIMORE CITY OR COUNTY OF DEATH <b>CHARLES</b> MD						
10. CITY OR TOWN OF DEATH <b>White Plains</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RE #1 Box 275</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		13a. STATE <b>MD</b>				
13b. COUNTY <b>Chas.</b>		13c. CITY OR TOWN <b>White Plains</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>RE #1 Box 275 / 20695</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Edward Hamilton</b>				
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Frances Hamilton</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>218-36-8747</b>		17. INFORMANT ADDRESS <b>Son: Calvin Robey, White Plains, Md.</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Irreversible Respiratory Collapse</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Carcinoma, Colon.</b>		<b>20 day.</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma, transverse Colon.</b>		<b>20 months.</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

19a. DATE OF OPERATION <b>Sept 12, 1988</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Metastatic Carcinoma, abdomen</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1988</b> to <b>Oct 2nd 1988</b> , that (I) (we) lost saw the deceased alive on <b>October 2nd 1988</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Arthur O. Woody, MD</b>		DEGREE		22c. DATE SIGNED <b>Oct 2, 1988</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR O. WOODY, MD.</b>		22e. ADDRESS <b>Box 430 LA PLATA, MD. 20646.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/5/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>The Hunt Funeral Home, P.O. Box 156, Waldorf 20601</b>			

25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1988</b>		25b. REGISTRAR'S SIGNATURE <b>John H. ...</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 8 6 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Barbara Louise Roesler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-05-85</b>		2b. HOUR <b>5<sup>40</sup></b> A M
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 01 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <b>Staten Island N.Y.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b> MD.		
10. CITY OR TOWN OF DEATH <b>LaPlata</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper Pres. Organ, Inc.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md</b> 13b. COUNTY <b>Charles</b> 13c. CITY OR TOWN <b>MARLBURY</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Hillver</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Brantingham</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>106-18-4174</b>		17. INFORMANT NAME ADDRESS <b>Susan Collins 14505 Oak Cluster Drive Centerville, VA. 22020</b>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Misadventure Concerning Breast</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION <b>10/2/85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:26 10 5 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>LAPLATA, MD. 20646</b>	
22a. I certify that (1) (this hospital) attended the deceased from <b>10/2/85</b> to <b>10/5/85</b> , that (I/we) lost saw the deceased alive on <b>10/2/85</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (I/we) did not view the body after death.					
22b. SIGNATURE <b>G. W. WATHEN</b>		DEGREE <b>MS.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/5/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. W. WATHEN</b>		22e. ADDRESS <b>LAPLATA, MD. 20646</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-9-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MORAVIAN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>STATEN ISLAND RICHMOND N.Y.</b>
24. FUNERAL DIRECTOR NAME <b>MEISLOHN FUNERAL HOME</b>		ADDRESS <b>STATEN ISLAND, N.Y.</b>		25. DATE REC'D. BY REGISTRAR <b>OCT 9 1985</b>	
		26. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

MEDICAL CERTIFICATION

279

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP





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291033

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHWH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NICHOLE RAYANN STEVENS</b>		2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> MONTH DAY YEAR MATED <input checked="" type="checkbox"/> 10-12-1985		2b. HOUR 11:59 M	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YRS. <b>Feb 6 1969</b>	6. AGE (IN YEARS) LAST DAY YRS. <b>16</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10-13-1985</b>	7d. HOUR 1:01 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>		10. CITY OR TOWN OF DEATH <b>LaPlata</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		13a. STREET ADDRESS <b>6114 Ronna Circle / 20601</b>	
13b. CITY, OR TOWN <b>Waldorf</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>6114 Ronna Circle / 20601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Stevens</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Karen Chandler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT ADDRESS <b>Charles Stevens (same as #13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:51 P.M. 10-12-1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>1 car MVA</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>St Peter Church Rd, Waldorf Charles Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>H. M. Mahon</b>		TITLE (SPECIFY) <b>Charles</b>		DATE SIGNED <b>10-13-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>H. M. Mahon</b>		ADDRESS <b>58th Box 1020, LaPlata, Md 20642</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10-16-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Huntt Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf Charles Md.</b>		24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1985</b>	
ADDRESS <b>P.O. Box 156 Waldorf, Md 20601</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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Figure 1. The effect of the concentration of the initiator on the polymerization of *l*-lysine. The polymerization was carried out at 60°C for 24 h in the presence of 0.05 mol/L of *l*-lysine and 0.05 mol/L of NaCl. The concentration of the initiator was 0.001 mol/L (○), 0.002 mol/L (□), 0.003 mol/L (△), 0.004 mol/L (◇), 0.005 mol/L (×), 0.006 mol/L (●), 0.007 mol/L (○), 0.008 mol/L (□), 0.009 mol/L (△), 0.01 mol/L (◇), 0.011 mol/L (×), 0.012 mol/L (●), 0.013 mol/L (○), 0.014 mol/L (□), 0.015 mol/L (△), 0.016 mol/L (◇), 0.017 mol/L (×), 0.018 mol/L (●), 0.019 mol/L (○), 0.02 mol/L (□), 0.021 mol/L (△), 0.022 mol/L (◇), 0.023 mol/L (×), 0.024 mol/L (●), 0.025 mol/L (○), 0.026 mol/L (□), 0.027 mol/L (△), 0.028 mol/L (◇), 0.029 mol/L (×), 0.03 mol/L (●), 0.031 mol/L (○), 0.032 mol/L (□), 0.033 mol/L (△), 0.034 mol/L (◇), 0.035 mol/L (×), 0.036 mol/L (●), 0.037 mol/L (○), 0.038 mol/L (□), 0.039 mol/L (△), 0.04 mol/L (◇), 0.041 mol/L (×), 0.042 mol/L (●), 0.043 mol/L (○), 0.044 mol/L (□), 0.045 mol/L (△), 0.046 mol/L (◇), 0.047 mol/L (×), 0.048 mol/L (●), 0.049 mol/L (○), 0.05 mol/L (□), 0.051 mol/L (△), 0.052 mol/L (◇), 0.053 mol/L (×), 0.054 mol/L (●), 0.055 mol/L (○), 0.056 mol/L (□), 0.057 mol/L (△), 0.058 mol/L (◇), 0.059 mol/L (×), 0.06 mol/L (●), 0.061 mol/L (○), 0.062 mol/L (□), 0.063 mol/L (△), 0.064 mol/L (◇), 0.065 mol/L (×), 0.066 mol/L (●), 0.067 mol/L (○), 0.068 mol/L (□), 0.069 mol/L (△), 0.07 mol/L (◇), 0.071 mol/L (×), 0.072 mol/L (●), 0.073 mol/L (○), 0.074 mol/L (□), 0.075 mol/L (△), 0.076 mol/L (◇), 0.077 mol/L (×), 0.078 mol/L (●), 0.079 mol/L (○), 0.08 mol/L (□), 0.081 mol/L (△), 0.082 mol/L (◇), 0.083 mol/L (×), 0.084 mol/L (●), 0.085 mol/L (○), 0.086 mol/L (□), 0.087 mol/L (△), 0.088 mol/L (◇), 0.089 mol/L (×), 0.09 mol/L (●), 0.091 mol/L (○), 0.092 mol/L (□), 0.093 mol/L (△), 0.094 mol/L (◇), 0.095 mol/L (×), 0.096 mol/L (●), 0.097 mol/L (○), 0.098 mol/L (□), 0.099 mol/L (△), 0.1 mol/L (◇), 0.101 mol/L (×), 0.102 mol/L (●), 0.103 mol/L (○), 0.104 mol/L (□), 0.105 mol/L (△), 0.106 mol/L (◇), 0.107 mol/L (×), 0.108 mol/L (●), 0.109 mol/L (○), 0.11 mol/L (□), 0.111 mol/L (△), 0.112 mol/L (◇), 0.113 mol/L (×), 0.114 mol/L (●), 0.115 mol/L (○), 0.116 mol/L (□), 0.117 mol/L (△), 0.118 mol/L (◇), 0.119 mol/L (×), 0.12 mol/L (●), 0.121 mol/L (○), 0.122 mol/L (□), 0.123 mol/L (△), 0.124 mol/L (◇), 0.125 mol/L (×), 0.126 mol/L (●), 0.127 mol/L (○), 0.128 mol/L (□), 0.129 mol/L (△), 0.13 mol/L (◇), 0.131 mol/L (×), 0.132 mol/L (●), 0.133 mol/L (○), 0.134 mol/L (□), 0.135 mol/L (△), 0.136 mol/L (◇), 0.137 mol/L (×), 0.138 mol/L (●), 0.139 mol/L (○), 0.14 mol/L (□), 0.141 mol/L (△), 0.142 mol/L (◇), 0.143 mol/L (×), 0.144 mol/L (●), 0.145 mol/L (○), 0.146 mol/L (□), 0.147 mol/L (△), 0.148 mol/L (◇), 0.149 mol/L (×), 0.15 mol/L (●), 0.151 mol/L (○), 0.152 mol/L (□), 0.153 mol/L (△), 0.154 mol/L (◇), 0.155 mol/L (×), 0.156 mol/L (●), 0.157 mol/L (○), 0.158 mol/L (□), 0.159 mol/L (△), 0.16 mol/L (◇), 0.161 mol/L (×), 0.162 mol/L (●), 0.163 mol/L (○), 0.164 mol/L (□), 0.165 mol/L (△), 0.166 mol/L (◇), 0.167 mol/L (×), 0.168 mol/L (●), 0.169 mol/L (○), 0.17 mol/L (□), 0.171 mol/L (△), 0.172 mol/L (◇), 0.173 mol/L (×), 0.174 mol/L (●), 0.175 mol/L (○), 0.176 mol/L (□), 0.177 mol/L (△), 0.178 mol/L (◇), 0.179 mol/L (×), 0.18 mol/L (●), 0.181 mol/L (○), 0.182 mol/L (□), 0.183 mol/L (△), 0.184 mol/L (◇), 0.185 mol/L (×), 0.186 mol/L (●), 0.187 mol/L (○), 0.188 mol/L (□), 0.189 mol/L (△), 0.19 mol/L (◇), 0.191 mol/L (×), 0.192 mol/L (●), 0.193 mol/L (○), 0.194 mol/L (□), 0.195 mol/L (△), 0.196 mol/L (◇), 0.197 mol/L (×), 0.198 mol/L (●), 0.199 mol/L (○), 0.2 mol/L (□), 0.201 mol/L (△), 0.202 mol/L (◇), 0.203 mol/L (×), 0.204 mol/L (●), 0.205 mol/L (○), 0.206 mol/L (□), 0.207 mol/L (△), 0.208 mol/L (◇), 0.209 mol/L (×), 0.21 mol/L (●), 0.211 mol/L (○), 0.212 mol/L (□), 0.213 mol/L (△), 0.214 mol/L (◇), 0.215 mol/L (×), 0.216 mol/L (●), 0.217 mol/L (○), 0.218 mol/L (□), 0.219 mol/L (△), 0.22 mol/L (◇), 0.221 mol/L (×), 0.222 mol/L (●), 0.223 mol/L (○), 0.224 mol/L (□), 0.225 mol/L (△), 0.226 mol/L (◇), 0.227 mol/L (×), 0.228 mol/L (●), 0.229 mol/L (○), 0.23 mol/L (□), 0.231 mol/L (△), 0.232 mol/L (◇), 0.233 mol/L (×), 0.234 mol/L (●), 0.235 mol/L (○), 0.236 mol/L (□), 0.237 mol/L (△), 0.238 mol/L (◇), 0.239 mol/L (×), 0.24 mol/L (●), 0.241 mol/L (○), 0.242 mol/L (□), 0.243 mol/L (△), 0.244 mol/L (◇), 0.245 mol/L (×), 0.246 mol/L (●), 0.247 mol/L (○), 0.248 mol/L (□), 0.249 mol/L (△), 0.25 mol/L (◇), 0.251 mol/L (×), 0.252 mol/L (●), 0.253 mol/L (○), 0.254 mol/L (□), 0.255 mol/L (△), 0.256 mol/L (◇), 0.257 mol/L (×), 0.258 mol/L (●), 0.259 mol/L (○), 0.26 mol/L (□), 0.261 mol/L (△), 0.262 mol/L (◇), 0.263 mol/L (×), 0.264 mol/L (●), 0.265 mol/L (○), 0.266 mol/L (□), 0.267 mol/L (△), 0.268 mol/L (◇), 0.269 mol/L (×), 0.27 mol/L (●), 0.271 mol/L (○), 0.272 mol/L (□), 0.273 mol/L (△), 0.274 mol/L (◇), 0.275 mol/L (×), 0.276 mol/L (●), 0.277 mol/L (○), 0.278 mol/L (□), 0.279 mol/L (△), 0.28 mol/L (◇), 0.281 mol/L (×), 0.282 mol/L (●), 0.283 mol/L (○), 0.284 mol/L (□), 0.285 mol/L (△), 0.286 mol/L (◇), 0.287 mol/L (×), 0.288 mol/L (●), 0.289 mol/L (○), 0.29 mol/L (□), 0.291 mol/L (△), 0.292 mol/L (◇), 0.293 mol/L (×), 0.294 mol/L (●), 0.295 mol/L (○), 0.296 mol/L (□), 0.297 mol/L (△), 0.298 mol/L (◇), 0.299 mol/L (×), 0.3 mol/L (●), 0.301 mol/L (○), 0.302 mol/L (□), 0.303 mol/L (△), 0.304 mol/L (◇), 0.305 mol/L (×), 0.306 mol/L (●), 0.307 mol/L (○), 0.308 mol/L (□), 0.309 mol/L (△), 0.31 mol/L (◇), 0.311 mol/L (×), 0.312 mol/L (●), 0.313 mol/L (○), 0.314 mol/L (□), 0.315 mol/L (△), 0.316 mol/L (◇), 0.317 mol/L (×), 0.318 mol/L (●), 0.319 mol/L (○), 0.32 mol/L (□), 0.321 mol/L (△), 0.322 mol/L (◇), 0.323 mol/L (×), 0.324 mol/L (●), 0.325 mol/L (○), 0.326 mol/L (□), 0.327 mol/L (△), 0.328 mol/L (◇), 0.329 mol/L (×), 0.33 mol/L (●), 0.331 mol/L (○), 0.332 mol/L (□), 0.333 mol/L (△), 0.334 mol/L (◇), 0.335 mol/L (×), 0.336 mol/L (●), 0.337 mol/L (○), 0.338 mol/L (□), 0.339 mol/L (△), 0.34 mol/L (◇), 0.341 mol/L (×), 0.342 mol/L (●), 0.343 mol/L (○), 0.344 mol/L (□), 0.345 mol/L (△), 0.346 mol/L (◇), 0.347 mol/L (×), 0.348 mol/L (●), 0.349 mol/L (○), 0.35 mol/L (□), 0.351 mol/L (△), 0.352 mol/L (◇), 0.353 mol/L (×), 0.354 mol/L (●), 0.355 mol/L (○), 0.356 mol/L (□), 0.357 mol/L (△), 0.358 mol/L (◇), 0.359 mol/L (×), 0.36 mol/L (●), 0.361 mol/L (○), 0.362 mol/L (□), 0.363 mol/L (△), 0.364 mol/L (◇), 0.365 mol/L (×), 0.366 mol/L (●), 0.367 mol/L (○), 0.368 mol/L (□), 0.

304179

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DOROTHY CARRINE WASHINGTON				OCTOBER 19, 1985		5:19P <sup>M</sup>	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE	BLACK	OCT. 12, 1900		85 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND	UNITED STATES			CHARLES MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LA PLATA	PHYSICIANS MEMORIAL HOSPITAL			HOUSEWIFE		PRIVATE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
		MARYLAND		CHARLES		NANJEMOY	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FRANK DYSON		GEORGIANNA WILLS		13e. STREET ADDRESS / ZIP CODE			
				RT.1 BOX 64A/20662			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO N/A		213-32-9991A		Lola Carter Rt.1 Box64A Nanjemoy, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIO RESPIRATORY ARREST					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF STOMACH					
		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MALIGNANT RECTAL.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CITING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 10/13/85 to 10/19/85, that (I) (we) last saw the deceased alive on 10/19/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
[Signature]		10/20/85		SANJEEB MISHRA, M.D.			
22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					
WALDORF, MARYLAND 20601		BURIAL					
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
OCT. 24, 85		SMITH CHAPEL CH.		PISGAH CHARLES MD.			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
THORNTON'S FUNERAL HOME		OCT 23 1985		[Signature]			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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